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AUTHOR Wallace, Hilda
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ABSTRACT

This paper presents, from the worker's point of view, ways in which paraprofessionals have related to clients, agencies, and the community, in their own idiom, often giving and receiving help that the professional staff were unable to obtain. The author discusses in detail: (1) important aspects of the black community that relate to patient service and background of the worker; (2) the participation of Psychiatric Rehabilitation Workers in patient service, community involvement, and organizational structure; (3) ways in which the paraprofessional staff have worked through their problems together; (4) the Career Ladder which has been developed; (5) questions about the future of this group; and (6) dreams for tomorrow, for patients and staff. (Author/EK)

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*THE PARAPROFESSIONAL MENTAL HEALTH WORKER

WHAT ARE WE ALL ABOUT?

Hilda Wallace

Psychiatric Rehabilitation Technician

Division of Rehabilitation Services

Department of Psychiatry

Harlem Hospital Center

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THE PARAPROFESSIONAL MENTAL HEALTH WORKER: WHAT ARE WE ALL ABOUT?

A popular topic in the recent years has been the innovative utilization of paraprofessional Mental Health Workers, but almost none of this writing has been by the paraprofessional group itself. This paper will present, from the worker's point of view, some of the ways in which paraprofessionals have related to clients, agencies, and the community, in their own idiom, often giving and receiving help that the professional staff were unable to obtain.

At the Harlem Rehabilitation Center (which, as the community-based facility of the Division of Rehabilitation Services, is part of the Department of Psychiatry, Harlem Hospital Center) Paraprofessional Psychiatric Rehabilitation Workers have demonstrated their effectiveness in the staff-patient team. They have contributed to program design and assisted professionals in the development of a pragmatic service model.

Thus, leadership ability, creativeness and organization have been brought into focus in the Center with the help of the paraprofessional worker. This approach is of paticular significance in our urban, black ghetto.

This paper will discuss:

(a) Important aspects of the black community that relate to patient service and backgrounds of the workers

(b) The participation of Psychiatric Rehabilitation Workers in patients service, community involvement

and organizational structure

(c) The ways in which paraprofessional staff have worked through their problems together

(d) The Career Ladder which has been developed

(e) Questions about the future of this group

(f) Dreams for tomorrow, for patients and for staff

The hiring criteria state that the paraprofessional must come from the ghetto area and have at least a seventh grade education. Characteristics that are also looked for in the potential employee are:

(1) A capacity for compassion, understanding and dedication.

(2) An ability to work in a group setting. Examples of their skills, knowledge and dedication will be illustrated throughout the presentation.

The paraprofessionals are housewives, mothers, welfare recipients, men and women who have been incarcerated, high school dropouts, ex-drug users, and some who have been admitted with psychiatric diagnosis.

We do not profess to be geniuses, but we do know the name of the game. First of all, we are black but proud, and this makes us fight all the harder; we are considered poor, but we have been, and still are, struggling to overcome this stigma; we are supposed to be uneducated, but some of us are obtaining our High School Equivalency Diplomas and others are striving to continue their education

by attending colleges and universities; many of us have resided in the ghetto, and still do, and know how hard it is to survive. In the ghetto, we pay exorbitant rents -- as much as $185 for four rooms-- in addition to being overcharged for staples, household goods and appliances. Some of us are parents who have been on welfare and know the stigma it leaves on our children. When we say, "Our children," it is because from the start, when they enter school, they are made aware of a difference between themselves and the other pupils. The most overt act is in the purchase of lunch tickets. The welfare recipient's ticket is different. To avoid embarrassment, many children do not eat lunch. Men and women who have been incarcerated, and released without training, find it extremely difficult to obtain gainful employment. When it comes to relating to the system, and relating to others, one of our biggest assets is, we can relate to each other because we come from similar environmental backgrounds.

When the Pilot Program began in 1964, there were only three professionals, some volunteers, and two part-time Harlem Domestic Peace Corpsmen. The volunteers, who were in the program before the Peace Corpsmen, were unable to meet the needs of the members because of home and outside commitments. Therefore, most of the patient responsibilities were assigned to the two part-time workers.

At that time, they were only being paid $30.00 per week, and volunteered their services beyound the time they were paid. At times, they put in as much as ten and twelve hours a day. They acted as Health Service Workers, Case Workers, Activity Workers, and liaison for community contacts with other agencies that would be helpful to our members and to our agency.

The client population at that time averaged between 25 and 30.

The focus of the program was socialization. The first giant step was to get clients involved in the community. Once out in the community, this would bring into focus other reality problems such as housing, welfare, health, education, and ordinary day-to-day living.

The two Peace Corpsmen started out by getting outside agencies, tenant's leagues, churches, stores, etc., involved in helping give outside activities that would involve our members. It was not an easy task because, although we came form the comm; nity, agencies and people in the community were hesitant about becoming involved with psychiatric patients. The Peace Corps was the starting point in helping others to understand the job we were trying to do. Relatives and friends were also instrumental in working along with us.

The professionals at the Rehabilitation Center were quite

aware of the difficulties we were encountering at the hospital and at outside agencies. They started opening doors that we could not, and in return, we opened doors and volunteered information that was useful and helpful to our members.

From 1964 to March 1967, the program moved from various community centers in Upper Manhattan. All member activities were limited by virtue of being confined to the one room. The Pilot Program had limited structure for the workers because of inadequate space. We had some ongoing training, in the sense that we would all meet together two or three times weekly in the hallway of that particular center, or wherever space was available, to discuss member problems and make recommendations. Other meetings took place at Harlem Hospital, or in the office that was leased temporarily, which was located about nine or ten blocks away. It was difficult to reach because of its location, and it was too expensive for the Peace Corpsmen to be riding back and forth; therefore, we did a lot of traveling on foot. We had meetings any and every place.

I can remember a day when we were located at the YWCA and had planned a meeting at the office. There had been a snowstorm. On the way over, Dr. Christmas decided to discuss some problems with the Psychiatric Nurse. We could hardly walk, much less talk, but since Dr. Christmas is always so energetic, she continued to

try to solve some problems until the nurse decided to tell her, "This is just a little ridiculous; let us at least make it to our destination."

One of the workers (who was a Peace Corpsman at that time and who is presenting this paper) was quitting every month because of all the stresses, and as she felt, the inhuman ways that clients were being treated.

With continued training, meetings and understanding, we began to get our bearings. We knew the program was expanding and we needed more structure, organization, workers, and space. The program did not fall apart because of these obstacles we were encountering, they united us closer.

Dr. June Jackson Christmas, Chief of the Division of Rehabilitation Services, saw the need for an agency that would and could coordinate services to patients. She submitted a proposal to the National Institute of Mental Health, which was accepted and funded. With this beginning, other Peace Corpsmen were hired, and our Paraprofessional movement was born.

Because our member population and staff was expanding, we needed a permanent facility to service members. After many months of searching for a place that would be located in the community and serve our catchment area, a warehouse owned by the Posner Corporation was found and remodeled, and this became the Harlem

Rehabilitation Center.

The Peace Corpsmen that started in the Pilot Program did not have the intensive, on-going training that the later group of workers received when hired. We had one social worker and one psychiatric nurse (and the psychiatrist at times) who made home visits with the workers.

Some of the paraprofessional workers were not used to organizational structure and found it difficult to conform, either to structure, or to organization. In order to give the program structure, and in order to help the workers, a professional was placed in charge of each unit, such as health, clinical and case services. Workers were given supervision, but with freedom to contribute their suggestions and ideas to making a better and more constructive program.

The members that originally started with us moved to the Rehabilitation Center with us in 1967. It was realized that, with the hiring of new staff, the program had to be more structured. We were no longer in the embryo stages and needed more training, structure, and organization in all units. The units were comprised of Health, Social and Clinical services. One service was dependent upon the other in giving efficient services to members. This is why we used the team approach.

If you use the team model along with ongoing training such as Group Activity Techniques, Workshops, also, meetings such as Therapeutic Community Meetings, Psychiatric Rehabilitation Worker Meetings, individual staff conferences and total Therapeutic Community Meetings, you will have a successful program.

One of our biggest problems, I think, is the one of paraprofessionals and professionals competing for leadership and status can be attributed to some of these factors: difference in their educational background, peer relationship, life experiences and their drive to be on the tip.

Another problems is that usually, the women outnumber the men, and are the Directors or Supervisors in the different divisions. The point that is often overlooked is that if you did not have the capabilities and knowhow, you would not hold these key positions. Also, if you know your potential and want to move up to higher positions, then it is up to the individual to strive to reach his goal. This problem exists in any agency, or within any social circle.

In our Sensitivity Meetings, problems were and are aired and, at times, resolved. At times, problems have taken months to resolve, but at least we knew that they were up for discussion and would eventually be resolved if pursued by staff.

Responsibilities of paraprofessional workers assigned to the various units and specialities include the following:

PSYCHIATRIC REHABILITATION WORKER

1. Participates in organizing and carrying out socio-therapeutic activities.
2. Functions as group leader in member-worker meetings.
3. Assists patients in developing group leadership and patient participant roles in member meetings.
4. Facilitates patient movement in specific adjustment activities to which patients are assigned.
5. Participates in therapeutic community meeting.
6. Participates in all discussion group meetings.
7. Assists in following through on activities with patients that are related to discussion groups.
8. Assists in evaluating patient movement, i.e., skill development, interpersonal and group interaction, problem solving.
9. Records and pulls together materials for reports and presentations.
10. Participates in case Summary Conference, presenting areas for discussion.
11. Brings medical, family and psychiatric situations to appropriate staff.
12. Assists in home visiting and family and community services, upon occasion.
13. Assists in exploring and incorporating new ideas into the rehabilitation setting.
14. Assists in the selection and purchasing of supplies.

The Psychiatric Rehabilitation Worker is known as:

Research Worker, Case Service Worker, Health Service Worker Psychiatric Rehabilitation Technician; which is my position.

My duties are:

(1) Carry out all the general duties noted under Psychiatric Rehabilitation Worker.

(2) Carry out certain specific duties rated under Psychiatric Rehabilitation Worker with certain differences.

The Technician functions in a specialty area or as a generalist; The Technician functions with higher skills greater independence, and less supervision. My assigned tasks require leadership and initiative. I may have the responsibility for a larger number of patients, clients, members and trainees.

THE EDUCATIONAL WORKER -

Performs and records periodic services, observations and evaluations, collects, records and maintains educational files and relevant data.

VOCATIONAL WORKER -

Observes through evaluation the work capabilities, vocational strengths and limitation, and work adjustment potential of the individual client, in the Rehabilitation Center.

A Career Lader has been established for the workers in the Center, with the support of the Drug and Hospital Union, Local 1199, and administration. There are four levels, with grades within each level:

1. Trainee
2. Worker
3. Technician
4. Specialist

You are a Trainee for six months, then a permanent Worker, if your evaluation meets with approval of all units. Workers are evaluated by their work performance during the first six months. All workers are evaluated after a year. The evaluations are read by the workers and then signed. This helps the workers to know their strengths and weaknesses.

The question is often asked as a person moves up in the Career Ladder: "Can he/she still identify with members/clients?" Psychiatric patients have been ill treated, misunderstood, and misguided for so long it takes time, understanding, compassion and dedication to help clients to know that there are people who care and, want to help them and they can relate to. The workers at the Division of Rehabilitation Service at the Center is a living example of one who is dedicated and compassionate. The mere fact that clients, after being terminated at the Center, maintain an on-going relationship with staff either by personal contact or phone, especially when a problem arises.

A member who has not been in the program for the past 3 years called the technician asking her to help her to get back on welfare.

She had been ill for several weeks with a heart condition and could not go back to work, This client was told that the coordinator of clinical services would have to be consulted before any action was taken. The coordinator stated that since the client was no longer in the program we did not have any responsibility to the client but offer our services to her in helping to get her to the doctor, and contacting welfare, asking them to give her whatever assistance was needed. Before the technician could help the client she had contacted her own doctor and after a few days got in touch with welfare and is now receiving welfare assistance. The client called to express her thanks for the concern the program showed, knowing she was no longer in the program.

WHAT IS A PROFESSIONAL, WHAT IS EXPERTISE?

A Professional is considered one who is in a business or profession or usually has acquired a college degree. In some practices where a license is required by law, a self taught individual may acquire one by passing exams prepared by authorities in that particular field.

To move to higher positions your must be qualified to obtain that position. In defining the word expertise, you can describe a quality possessed by the rehabilitation workers. Since many of the workers are trained or have received similar job experiences

and are self taught they are considered to have expertise in their field. Many have brought knowledge to the Center that have been programmed into the activities, such as: Arts and Crafts, Culinary Art, Community Organizing, sewing, remedial skills, budgeting, and designing. Above all they can relate and bring client-worker cohesiveness.

THE DREAMS OF TOMMORROW FOR THE PARAPROFESSIONAL WORKER ARE:

1. To further their education.

2. To receive college credits for their years of service.

3. To be credentiated in order to move out of their agency if they so desire without a change in salary of status.

Dreams for extended services included a Half-Way House for clients served from the community and client sponsored small businesses.

As a paraprofessional, who is the Psychiatric Rehabilitation Technician it has been a dream to have a Half-Way House for psychiatric patients/clients.

A Half-Way House would serve two purposes such as:

(I) Clients who attend the psychiatric rehabilitation program are mostly welfare recipients and formally hospitalized state institution patients, walk ins and from after care clinics. At times, these clients need immediate

housing accommodations. When trying to obtain rooms, apartments or hotel lodgings, references are quite often required. When the person who is renting finds out that the client's age is thirty or forty the renting agent, will ask: "Why is the person on welfare?"

When it is stated that they are disabled, the next question is: "What kind of disability is it?" Apprehension is always shown when you state that the person is disabled. The renting agent is concerned about what kind of involvement am I getting into with renting to a disabled person? When you state that they are well stable, psychiatric clients who are able to function in the community the answer to that is: "We do not cater to those type of people."

Because they are welfare recipients hotels charge exorbitant fees, such as eighteen dollars ($18.00) per day. Many will state that there is no rooms available or they have to pay nightly.

(2) Clients who live alone need the companionship of someone to be able to talk to after they leave the Center. If we can obtain houses and renovate them into homes, that we would like to live in, it could function as a community house. An advanced psychiatric rehabilitation worker could be trained as an administrative person assigned to each Half-Way House to give clients needed assurance. One or two clients would be trained with salary to act as housekeeper or just be the person who other

clients can relate if an emergency comes up. Later on clients could be trained as assistants to the advance psychiatric rehabilitation worker on the premises or some other neighboring community, and be paid for their services. Clients could also act as consultants to other agencies giving their views and ideas in how they think a Half-Way House should be structured. The advance psychiatric worker would only be on the premises from 9-12. He/she would pick up any problems that might arise over night. The rest of the time would be utilized at the Rehabilitation Center.

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SUMMARY

The concept of New Careers can be summed up by the knowledge skills and potentials of the para-professionals at the Rehabilitation Center.

We have pulled together all segments of para-professionals. They are working together, exchanging ideas, giving themselves, and taking advantage of all oportunities to help further their careers. Also encouraging others to stand up and be counted, letting others know that they are there.

Given half a chance we can come together on all levels. Hopefully through continued effectiveness of programs and organizations, it can be proven all over the country that the para-professionals and professionals can work together and keep their own identity demonstrating in unity their is strength. This is what we are all about.